2026 ANNUAL CONFERENCE & EXPO
Celebrating 60 Years
Then. Now. Next.

Hospice Live Discharges

Kathy Ahearn, RN, BSN, PHN
www.alecc.com
kathy@alecc.com

ALECC
Educate Collaborate & Consult

June 2026

1

At the end of this presentation, the participant will be able to:

DEFINE	Define the five allowable types of hospice live discharge under the Conditions of Participation
EXPLAIN	Explain the benefits of the hospice live discharge process
Understand	Understand what reports are available to help you monitor your agencies Live Discharge percentages.
MONITOR	Monitor provider live discharge patterns and trends and discuss how they implicate the need for education and/or process improvement.
IDENTIFY	Identify changes that will help you improve your agency's hospice live discharge process.

2

CMS Hospice Monitoring Report

April 2026

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

3

Number of Beneficiaries by Principal DX Category FY 2021 - 2025

Exhibit 9b. Percentage (within a year) of Beneficiaries by Principal Diagnosis Category for FYs 2021-2025

Principal Diagnosis Category	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Alzheimer's, Dementia, or Parkinson's	23.2%	23.8%	24.1%	21.6%	21.9%
Cancers	22.9%	22.6%	22.6%	22.2%	21.7%
Cardiac (e.g., Congestive Heart Failure (CHF))	18.0%	18.3%	18.9%	19.2%	19.4%
Respiratory (e.g., Chronic Obstructive Pulmonary Disease (COPD))	10.2%	10.1%	10.1%	9.9%	9.9%
Cerebral Vascular Accident (CVA)/Stroke	10.1%	10.3%	10.5%	10.7%	11.0%
Chronic Kidney Disease (CKD)/End-Stage Renal Disease (ESRD)	2.2%	2.2%	2.1%	2.0%	2.0%
Other	13.4%	12.7%	11.8%	14.5%	14.2%

Source: Analyses of Medicare FFS hospice claims (Data for FY 2025 accessed from CCW VRDC on January 15, 2026 and data from FY 2021 – FY 2024 accessed on May 9, 2025)

https://www.cms.gov/files/document/hospice-monitoring-report-2026.pdf

4

Number of Beneficiaries by Principal DX Category FY 2021 - 2025

Key Takeaways:

- "Alzheimer's, Dementia, or Parkinson's" as a category was eclipsed in terms of beneficiaries by "Cancers" in FY 2024 for the first time since FY 2020, but in FY 2025 went back to the number one diagnosis category at 21.9%.
- Chronic Kidney Disease (CKD)/End-Stage Renal Disease (ESRD) is the diagnostic category with the fewest beneficiaries.
- The percentage of beneficiaries within each diagnostic category remains fairly consistent from FY 2021 through FY 2025.

https://www.cms.gov/files/document/hospice-monitoring-report-2026.pdf

5

Exhibit 5b. Percentage (within a year) of Beneficiaries by Hospice Lifetime Length of Stay (LOS) Category for FYs 2021-2025

Hospice Lifetime LOS	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
1-4 days	23.0%	22.3%	21.5%	21.1%	20.4%
5-10 days	18.1%	17.7%	17.4%	17.0%	16.4%
11-30 days	19.4%	19.5%	19.4%	19.1%	18.7%
31-60 days	10.6%	10.9 %	11.0%	10.9%	10.9%
61-90 days	5.6%	5.8%	5.9%	6.0%	6.0%
90-180 days	8.9%	9.2%	9.5%	9.7%	10.0%
181+ days	14.5%	14.6%	15.2%	16.2%	17.6%

Source: Analyses of Medicare FFS hospice claims (Data for FY 2025 accessed from CCW VRDC on January 15, 2026 and data from FY 2021 – FY 2024 accessed on May 9, 2025)

Key Takeaways:

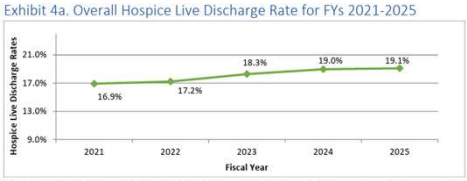
- Slightly over 20% of hospices users in the sample have a lifetime length of stay in hospice of between 1 and 4 days.
- In any given year, between 56% and 60% of beneficiaries in the sample have a lifetime length of stay of between 1 and 30 days.
- The distribution of stays has shifted slightly between FY 2021 and FY 2025 towards fewer short stays (≤ 60 days) and more long stays (≥ 61 days).

https://www.cms.gov/files/document/hospice-monitoring-report-2026.pdf

6

Live Discharges

Exhibit 4a. Overall Hospice Live Discharge Rate for FYs 2021-2025



Source: Analyses of Medicare FFS hospice claims (Data for FY 2025 accessed from CCW VRDC on January 15, 2026 and data from FY 2021 – FY 2024 accessed on May 9, 2025)

https://www.cms.gov/files/document/hospice-monitoring-report-2026.pdf

7

Live Discharges

Exhibit 4c. Percentage (within a year) of Live Discharges, Reason for Live Discharge, and Transfers for FYs 2021-2025

Reason for Discharge or Transfer	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
For Cause	1.8%	1.9%	2.2%	1.9%	2.1%
Revoke	36.1%	35.0%	34.6%	35.3%	35.8%
No Longer Terminally Ill	36.4%	36.0%	34.9%	33.0%	31.1%
Moved out of the Service Area	12.7%	14.2%	15.3%	16.3%	17.8%
Transferred Hospice	13.0%	12.9%	13.0%	13.6%	13.2%
Total	100.0%	100.0%	100.0%	100.0%	100.0%

https://www.cms.gov/files/document/hospice-monitoring-report-2026.pdf

8

Live Discharges

Key Takeaways:

- The overall percentage of live discharge has steadily increased between FY 2021 and FY 2025.
- The percentages of live discharge for cause and revocation have mostly stayed consistent over time. On the other hand, there has been a gradual decrease in the share of discharges who are no longer terminally ill and a gradual increase in those moving out of the service area between FY 2021 through FY 2025.

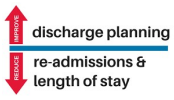
Exhibit 4 Methodology:

All hospice claims list a discharge status code. We exclude claims if they listed status code 30, indicating a continuing patient. Discharges ending in death had a discharge status code of 40, 41, or 42. Any claims not already excluded or that indicated a discharge resulting from death were considered live discharges. Refer to the Overall Methodology section of this report for additional details.

https://www.cms.gov/files/document/hospice-monitoring-report-2026.pdf

9

Hospice Live Discharges



10

Live Discharges

- Hospice live discharges is an area of concern and confusion for agencies and an area of scrutiny for CMS.
- State and private payer discharge conditions may differ from Medicare conditions, so always review what the primary payer requires before a live discharge.
- There are a limited number of reasons for a live discharge.
- Once an agency has admitted a patient on to service, it may not automatically or routinely discharge a patient.
  - There are specific discharge reasons allowed, and cost is not one of them!
  - Nor is it appropriate for a hospice to encourage, request, or demand a patient revoke their hospice election.

11

The Reality of Hospice of Live Discharges

Hospice providers are expected to have some rate of live discharges because:

- Patients change their minds and revoke their hospice benefit.
- Their condition improves and they no longer meet the hospice eligibility criteria.
- They may change hospice providers or move out of the hospice service area.
- Dementia, cardiovascular, and respiratory are the top three live discharge Dx categories.

Analyses showing hospices with higher rates of live discharge than their peer signal a potential problem with:

- Quality-of-care issues or program integrity.
- Could mean the hospice program is not meeting the needs of the patient and family.
- **Is admitting patients who do not meet the eligibility requirement.**
- This could indicate the hospice is admitting patients too soon.

12

Hospice Discharge

"Once a hospice chooses to admit a Medicare beneficiary, it may not automatically or routinely discharge the beneficiary at its discretion, even if the care promises to be costly or inconvenient, or the State allows for discharge under State requirements."

– Medicare Benefit Policy Manual Chapter 9

13

Reasons for Hospice Discharge

Discharge from the Medicare hospice benefit will occur because of one the following:

- **Patient Revocation:** A patient or authorized representative decides to revoke the hospice benefit.
- **Transfer:** A patient or authorized representative decides to transfer to another hospice.
- **Death:** The patient dies. (not a live discharge)
- **Hospice Discharge:**
  - The patient moves away from the geographic area that the hospice defines in its policies as its service area.
  - The patient's condition stabilizes or improves, and they are no longer considered terminally ill.
  - The patient is discharged for cause.

14

Hospice Live Discharges

Two Categories of Live Discharges:

1. Patient Choice (patient may initiate).
   - Revocation
   - Transfer
2. Hospice Choice
   - No longer terminally ill
   - Outside the coverage area
     - Pt chooses a facility in which hospice does not have a contract
   - Discharge for cause
     - Behavior is disruptive, abusive, or uncooperative

15

Federal Requirements

Medicare Conditions of Participation

- §418.26 Discharge from hospice care

(1) The patient moves out of the hospice's service area or transfers to another hospice.

(2) The hospice determines that the provider is no longer terminally ill.

(3) The hospice determines, under a policy set by the hospice for the purpose of addressing discharge for cause that the patient's (or other persons in the patient's home) behavior is disruptive, abusive, or uncooperative to the extent that delivery of care to the patient or the ability of the hospice to operate effectively is seriously impaired.

16

Federal Requirements

The hospice must do the following before it seeks to discharge a patient for cause:

- Advise the patient that a discharge for cause is being considered
- Make a serious effort to resolve the problem(s) presented by the patient's behavior or situation
- Ascertain that the patient's proposed discharge is not due to the patient's use of necessary hospice services
- Document the problem(s) and efforts made to resolve the problem(s) and enter this documentation into its medical records

17

Federal Requirements

Effect of Discharge

An individual, upon discharge from the hospice during a particular election period for reasons other than immediate transfer to another hospice:

1. Is no longer covered under Medicare for hospice care
2. Resumes Medicare coverage of the benefits waived under §418.24(d)
3. May at any time elect to receive hospice care if he or she is again eligible to receive the benefit

18

Federal Requirements – Discharge Planning

Discharge Planning

(1) The hospice must have in place a ***discharge planning process*** that considers the prospect that a patient's condition might stabilize or otherwise change such that the patient cannot continue to be certified as terminally ill.

(2) The ***discharge planning process*** must include planning for any necessary family counseling, patient education, or other services before the patient is discharged because he or she is no longer terminally ill.

19

Revocation and CoP's

§418.104(e)(2) – If a patient revokes the election of hospice care, or is discharged from hospice in accordance with §418.26, the hospice must forward to the patient's attending physician, a copy of (L683)

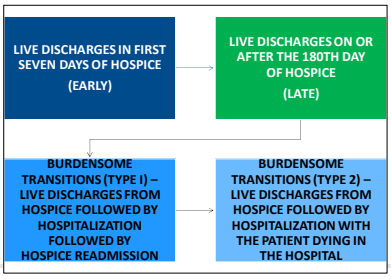
- The hospice discharge summary
- The patient's clinical record, if requested

§418.104(e)(3) – The hospice ***discharge summary*** as required by (e)(1) and (e)(2) of this section must include (L684):

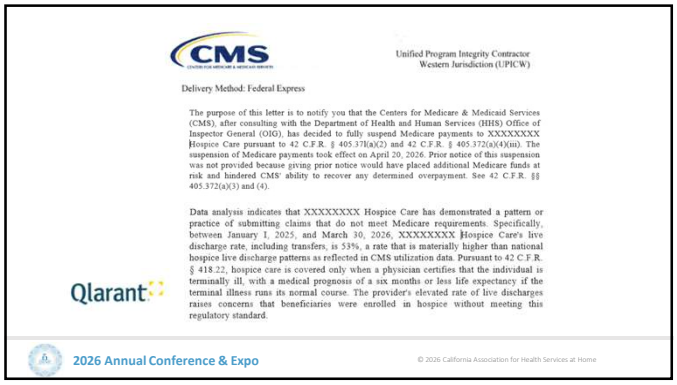
- A summary of the patient's stay including treatments, symptoms, and pain management
- The patient's current plan of care
- The patient's latest physician orders
- Any other documentation that will assist in post-discharge continuity of care or that is requested by the attending physician or receiving facility

20

Live Discharges – Impact Quality Reporting/Medicare Payments



21



CMS

Unified Program Integrity Contractor
Western Jurisdiction (UPICW)

Delivery Method: Federal Express

The purpose of this letter is to notify you that the Centers for Medicare & Medicaid Services (CMS), after consulting with the Department of Health and Human Services (HHS) Office of Inspector General (OIG), has decided to fully suspend Medicare payments to XXXXXXXX Hospice Care pursuant to 42 C.F.R. § 405.371(a)(2) and 42 C.F.R. § 405.372(a)(4)(iii). The suspension of Medicare payments took effect on April 20, 2026. Prior notice of this suspension was not provided because giving prior notice would have placed additional Medicare funds at risk and hindered CMS' ability to recover any determined overpayment. See 42 C.F.R. §§ 405.372(a)(3) and (4).

Data analysis indicates that XXXXXXXX Hospice Care has demonstrated a pattern or practice of submitting claims that do not meet Medicare requirements. Specifically, between January 1, 2025, and March 30, 2026, XXXXXXXX Hospice Care's live discharge rate, including transfers, is 53%, a rate that is materially higher than national hospice live discharge patterns as reflected in CMS utilization data. Pursuant to 42 C.F.R. § 418.22, hospice care is covered only when a physician certifies that the individual is terminally ill, with a medical prognosis of a six months or less life expectancy if the terminal illness runs its normal course. The provider's elevated rate of live discharges raises concerns that beneficiaries were enrolled in hospice without meeting this regulatory standard.

Qlarant

22

Hospice Care Index (HCI) Reporting

TABLE 5: Quality Measures finalized in the FY 2022 Hospice Wage Index Final Rule and in Effect for FY 2023 for the Hospice Quality Reporting Program

Administrative Data, including Claims-based Measures	
3645	Hospice Visits in Last Days of Life (HVLDL)
Pending NQF endorsement	Hospice Care Index (HCI) 1. Continuous Home Care (CHC) or General Inpatient (GIP) Provided 2. Gaps in Skilled Nursing Visits 3. Early Live Discharges 4. Late Live Discharges 5. Burdensome Transitions (Type 1) – Live Discharges from Hospice Followed by Hospitalization and Subsequent Hospice Readmission 6. Burdensome Transitions (Type 2) – Live Discharges from Hospice Followed by Hospitalization with the Patient Dying in the Hospital 7. Per-beneficiary Medicare Spending 8. Skilled Nursing Care Minutes per Routine Home Care (RHC) Day 9. Skilled Nursing Minutes on Weekends 10. Visits Near Death

23

When Is an MD Order Required For Discharge?

- Attending physician should be consulted before discharge and his or her review and decision included in the discharge note.
- Hospice must obtain a written physician's discharge order from the hospice physician for three discharge reasons.
- Order Required for Hospice Live Discharge:
  - DC with Cause
  - DC – Not Medically Eligible
  - DC – Out of Service Area
- No Order Required for Patient Choice for Discharge:
  - DC – Revocation
  - DC – Transfer

24

Discharge by Patient – Revocation

When a beneficiary enrolls in hospice, he/she is instructed to coordinate all their care through the hospice agency or else it might not be covered by Medicare.

Hospice providers are not required to pay for emergency or non-emergency services not coordinated by hospice. Patients going to the hospital for reasons related to their diagnosis do not automatically equal revocation.

25

Revocation §418.28

A hospice may never "revoke a patient."

A hospice has a responsibility to counsel the beneficiary on the availability of revocation.

The beneficiary does not have to provide a reason for revocation.

Hospice documentation should include the circumstances around the revocation.

26

Revocation §418.28 Considerations Per the Regulations

- Generally Patient and/or family (cg) initiated.
- Requests revocation of the hospice.
- Upon revoking, the individual loses hospice coverage for any remaining days in that specific election period.
- Patient signs a statement of revocation on the effective date:
  - Must complete the revocation statement in writing – no accommodation for a verbal revocation.
- A revocation cannot be back-dated.

27

Common Reasons for Revocation

Patient Choice to Revoke Hospice Because:

- Seeking aggressive treatment.
- No longer wish to remain in the Medicare hospice benefit.
  - Poor understanding of Medicare hospice benefit.
- In a nursing facility and/or patient chooses a skilled bed.
- Exacerbation of symptoms and family takes patient to hospital for symptom control.
  - Family has difficulty handling a symptom "OOC" – requires ongoing education with each hospice visit. (Symptom management is critical.)

28

Patient Choice = Revocation

Revocation Prevention

- Educate the patient/caregiver to call hospice first!!
- Educate re: expectations of hospice.
- Have the Hospice agency phone # plastered everywhere in the patient home to call first!
- Educate the cg about the disease process (books, videos).
- Provide caregiver with interventions he/she can provide during symptom exacerbation or times of emotional insecurity (symptom management).
- Utilize other disciplines in providing emotional support to patient/caregiver who are overly anxious or having difficulty accepting the disease process (MSW, chaplain, volunteers).
- Promote importance to staff of "being available" to patient/caregiver – increase visit frequency of all staff as needed, especially during the first week!
- Instill confidence to patient/caregiver of our ability to provide a higher quality of life and keep their symptoms managed at end of life (pain).

29

Revocation Documentation

Any paperwork that is required by your agency's policy and procedure, can include but not limited to:

- Hospice Revocation Form, signed and dated by patient/caregiver with effective date
- Discipline narrative and IDT note
- Discharge summary
- Revocations cannot be verbal

The Notice of Termination/Revocation NOTR, Type of Bill (TOB 8XB) is filed upon revocation of the Hospice benefit if the final claim has not been submitted. This must be done within five days of revoking.

- Effective 7-1-2018 an NOTR could be submitted on an open election in the Common Working File
- Preference is still to file a final claim

30

Discharge by Patient Transfer

418.30 – Transfer

- One transfer allowed per benefit period
- Second change would require revocation or D/C (if patient leaving service area) with a reelection
- Beneficiary must file statement that includes the:
  a. Name of original hospice
  b. Name of new hospice
  c. Date the change is to be effective

31

Transfer Documentation for Continuum of Care

Hospice Sending a Transfer, Recommended for a Smooth Transition and Transfer:

- Change of provider form
- Face to face
- Most recent plan of care
- Current medication list
- Discharge summary
- Good to send patients' election of the hospice benefit and certificate of death to receiving hospice
- Final bill should list as a "transfer" not a discharge

32

Transfer Documentation for Continuum of Care

Hospice Receiving a Transfer:

New notice of election not needed. Coordinate with sending hospice 8XC when to file after final claim has been submitted

- See patient's election of the hospice benefit from sending hospice along with their certification of death

Face to face if patient is in 3rd or later benefit period (must be able to prove face to face was completed)

Plan of care (update)

Med list

Physician order

Consent for care to your agency must be signed

33

Critical Criteria to Remember With Transfer

1. Only “one” transfer is allowed per Medicare benefit period
2. Second transfer would require a discharge or revocation from hospice with a re-election of the benefit
3. Same benefit period, no need to file NOE (8XA)
4. Must have “good communication” between sending and receiving hospice to coordinate filing of final claim and 8XC form
5. Receiving hospice should view the original NOE and certification of death
6. Both providers are paid for the day of transfer

34

Discharge by Hospice

Hospice provider may initiate if:

1. Patient moves out of service area
2. Patient is no longer deemed terminally ill
   - The hospice is unable to support terminality in documentation
3. Chooses facility in which hospice does not have a contract
4. Behavior is disruptive, abusive, or is uncooperative

Do not always discharge in haste or panic discharge, explore all alternatives. Discuss in IDG – a team agrees!

35

Discharge by Hospice Medically Ineligible

§418.26

Eligibility for the hospice Medicare benefit requires a life-expectancy of six months or less.

If the hospice determines that a beneficiary, no longer meets that requirement they must discharge.

36

Discharge by Hospice Medically Ineligible

Hospices are required to continue to evaluate eligibility during the period the beneficiary is under care and to discharge if no longer eligible.

- Hospice must consider the possibility of patients stabilizing and/or improving.
- Patients should be ***consistently evaluated*** for stabilization or consistent improvement.
  - Visit notes of "all disciplines," IDG, F2F.

May be at the end or in the middle of a benefit period.

"No longer terminally ill discharges" are NEVER a last-minute decision.

37

Medical Ineligibility: Discharge Planning

CMS notes: "Discharge is not expected to be the result of a single moment that does not allow time for some post-discharge planning."

- ✓ When there are indications of improvement in the individual's condition such that the patient may soon no longer be eligible, then discharge planning should begin.
- ✓ Discharge planning is expected to be a process, and planning should begin before the discharge date.
- ✓ Document prudently.

38

Discharge by Hospice Medically Ineligible

Once the decision to discharge is made with the IDT, the patient/caregiver must be notified of the decision, along with their right to appeal.

Once the IDT agrees to discharge, discharge planning begins, and the patient/caregiver is notified.

- Discharge is determined by the "team" and discussion for possible discharge should be reflected in IDT notes prior to discharge.
- Evidence of ongoing review of medical eligibility for patient to remain on hospice.

39

Medically Ineligible Live Discharge

Discharge planning process involving the IDT team
Obtain physician's order to discharge (medical director/primary)
Deliver Notice of Medicare Non-Coverage Form (NOMNC) (no later than 48 hours prior to d/c)
If pt/cg choose to appeal give them Detailed Explanation of Non-Coverage (DENC)
Referral to outside agencies, back to attending physician notifying of discharge
Home health/home care/ALF?
Community resources
Counseling services – no longer dying now what? Can the patient re-elect hospice in the future?
Medical equipment – DME/pharmacy/supplies – considerations on who will cover what now?

40

Advance Beneficiary Notice

Advance Beneficiary Notice (ABN)-CMS-R-131

- Issued when service continues but beneficiary is considered no longer terminally ill
- Level of hospice care is determined to be not reasonable or medically necessary
- Specific items or services that are billed separately from the hospice benefit and are not reasonable and necessary
- Not issued for revocations
- Respite care beyond five consecutive days

41

Expedited Determination Notices

Generic Notice of Medicare Non-Coverage (NOMNC)-CMS10123

- Used for live discharges determined no longer terminally ill.
- Valid notice delivered at least two days prior to termination of services and informs patient/caregiver that Medicare will probably cease to pay for hospice services due to patient no longer meeting hospice criteria.
  - Must be given no later than two days prior to end of coverage. End date must be listed on form.
  - Some states have stricter guidelines. More stringent guideline must be followed.

42

Expedited Determination Notices

- Should be verbally reviewed with the patient and/or cg for complete understanding.
- If patient and/or cg agree with decision, services end on the day listed on the NOMNC.
- If patient and/or cg does not agree with the decision, then a Detailed Explanation of Non-Coverage (DENC) must be filed.
- Not issued for:
  - Discharged for cause
  - Revocations

43

Detailed Explanation of Non-Coverage

A Medicare provider or health plan (Medicare advantage plans and cost plans, collectively referred to as "plans") must deliver a completed copy of this notice to beneficiaries/enrollees receiving covered skilled nursing, home health, comprehensive outpatient rehabilitation facility, and hospice services upon notice from the Quality Improvement Organization (QIO) that the beneficiary/enrollee has appealed the termination of services in these settings.

The Detailed Explanation of Non-Coverage (DENC) must be provided no later than close of business of the day of the QIO's notification.

44

Explanation of Non-Coverage

- If the patient appeals the discharge decision, the Hospice is required to continue care for patient until decision is delivered by QIO (Quality Improvement Organization)
- QIO will verbally notify hospice and will mail a letter to the hospice detailing decision
- Communication between hospice and QIO must be documented and filed in chart
- If QIO agree with hospice decision, hospice services end on the day hospice is notified
- If QIO disagree with hospice decision, hospice services continue

45

Completing DENC Form

Heading:

Insert contact information here: Name, address and telephone number of the provider or plan that delivers the notice must appear above the title of the form.

Date: Fill in the date the notice is generated by the provider or plan.

Patient Name: Fill in the beneficiary's/enrollee's first and last name.

Member number: Fill in the beneficiary's/enrollee's medical record or identification number. The beneficiary's/enrollee's HIC number must not be used.

{Insert type}: Insert the kind of service being terminated, i.e., skilled nursing, home health, comprehensive outpatient rehabilitation service, or hospice.

Bullet # 1 The facts used to make this decision: Fill in the patient specific information that describes the current functioning and progress of the beneficiary/enrollee with respect to the services being provided. Use full sentences, in plain English.

46

Completing DENC Form – Explanation

Bullet # 2 The detailed explanation of why the services are no longer covered. Fill in the detailed and specific reasons why services are either no longer reasonable or necessary for the beneficiary/enrollee or are no longer covered according to the Form Instructions CMS-10124-DENC OMB Approval No. 0938-xxxx.

- Medicare guidelines. Describe how the beneficiary/enrollee does not meet these guidelines.

Bullet # 3 (Plans only) The plan policy, provision, or rationale used in the decision if the notice is delivered to a health plan enrollee: Fill in the reasons services are no longer covered according to the plan's policy guidelines, if applicable. Describe how the enrollee does not meet these guidelines. If the plan relied exclusively on Medicare coverage guidelines, please explain that here.

- **If you would like a copy of the policy:** If the plan has not provided the Medicare guidelines or policy used to decide the termination date, inform the beneficiary/enrollee how and where to obtain the policy. Provide a telephone number for beneficiaries/enrollees to get a copy of the relevant documents sent to the QIO.

47

Critical Documentation for Your Files: Discharge No Longer Terminally Ill

- **Physician's Order for Discharge** — **Notification to Attending Physician**
- **Discharge Summary**
- **Discharge Checklist**
- **NOMNC and DENC (if appealed)**
- **Discipline narratives and IDT updates with detailed information of circumstances surrounding discharge, education of patient/caregiver, and delivery of NOMNC/DENC**
- **Coordination of Care Continuum** — **Include all appropriate referrals**

48

Discharge: Medically Ineligible

Preventing a Burdensome Transition

Patient/caregiver education, what is critical?

Medication, treatments, and supplies, etc.

Follow up with referrals and attending physician.

Care continuum and "options" to help manage care.

Reelection of hospice services in the future.

Understanding the Medicare hospice benefit now and in your future.

49

Discharge by Hospice: Discharge for Cause

The Rule:

When a hospice determines, under a policy set by the hospice for the purpose of addressing discharge for cause, that the patient's (or other persons in the patient's home) behavior is **disruptive**, **abusive**, or **uncooperative** to the extent that **delivery of care** to the patient or the **ability of the hospice to operate effectively** is seriously impaired, the hospice can consider discharge for cause.

When does this usually apply?? – Safety reasons.

Unable to deliver care per the POC.

Notify MAC (billing codes) and State Survey Agency.

50

Discharge by Hospice: Discharge for Cause Considerations 418.28

Hospice must make **every** effort to resolve the problem satisfactorily before discharge for cause is an option.

Efforts to resolve the problem must be documented in detail in the EMR.

Social workers need immediate involvement when discharge for cause is being considered.

Open conversations between hospice staff and patient/caregiver must take place prior to discharge.

Each hospice must formulate its own discharge policy and apply it equally to all patients

51

Steps the Hospice Must Take Prior to Discharge

Advise	Advise the patient discharge for cause is being considered
Make	A serious effort to resolve the problem
Determine	If there is an underlying reason for discharge.
Document	The problem and efforts made to resolve the problem, in detail, in the EMR

52

Critical Documentation for Your Files: Discharge For Cause

- **Physician's Order**
- **Discharge Summary**
- **Discharge Checklist**
- **Discipline Narratives and IDT Updates With Detailed Information of Circumstances Surrounding Discharge**
- **Referrals, Continuum of Care, Attending Physician Update** — **Home Health, Hospice, Home Care**
- **Information on Notice to Elect Hospice Benefit in the Future if No Hospice Referral**

53

Discharge by Hospice: Outside The Coverage Area

§418.26

- Beneficiaries that leave the service area
- Beneficiaries that are admitted to a hospital within the service area with which the hospice does not have a contract
- Hospice does not need to discharge immediately where there is not a contract but rather show evidence of:
  - Document attempts to establish contract
  - If not discharged, beneficiary will be liable for the facility charges
  - Re-admit after discharge; if third or subsequent benefit period will need a F2F

54

Reasons to Discharge: Outside the Coverage Area

The Patient:

- Moves out of the provider's service area
- Is traveling (greater than 14 days)
- Is admitted to a hospital, for a hospice-related reason, that does not have a contractual relationship with the hospice and a contract cannot be established
- Is admitted to a hospital, for an un-related hospice reason, but whose length of stay is expected to be lengthy
- Is admitted to a SNF that does not have a contractual relationship with the hospice

55

Critical Documentation for Your Files: Discharge Outside of Service Area

- Physician's Order
- Discharge Summary
- Discharge Checklist
- Discipline Narratives and IDT Updates With Detailed Information of Circumstances Surrounding Discharge
- Referrals, Continuum of Care, Attending Physician Update — Home Health, Hospice, Home Care
- Information on Notice to Elect Hospice Benefit in the Future if No Hospice Referral

56

Coding and Reports

57

CMS Gathers Hospice Live Discharge Data

- Medicare Claims (UB-04) – Primary source for tracking the reason for live discharges (e.g. revocations, no longer terminally ill, transfers).
- Hospice Item Set (HIS) – submit records within 30 days of discharge (now the HOPE Tool).
- Care Compare – Data compiled from CAHPS/HIS later HOPE.
- PECOS – make certain all enrollment info is correct.
- PEPPER Reports.

58

Live Discharges and Coding

Discharge Reason	Coding Required in Addition to Patient Status Code	Notes
Beneficiary revokes	Occurrence Code 42	Only for revocation
Beneficiary transfers to another hospice	Patient Status Code 50 or 51 No other indicator necessary	Does not terminate patients current benefit period
Beneficiary no longer terminally ill	No other indicator necessary	This is applicable for a patient with a missed/late face-to-face visit
Beneficiary discharged for cause	Condition H2	Used when patient meets agency policy to discharge for cause
Beneficiary moves out of service area	Condition 52	• Moves out of service area • On vacation • Admitted to hospital or SNF where hospice does not have a contract

59

PEPPER (Program for Evaluating Payment Patterns Electronic Report)

https://pepper.cbrpepper.org/index.html

60

What is PEPPER?

- A report that contains an agencies claims data statistics obtained from UB-40 claim forms and submitted to agencies MAC.
- National hospice claims data was analyzed to identify areas within the Medicare hospice benefit that could be at risk for improper Medicare payment.
  - These areas are identified as "target areas."
- Each hospice receives a PEPPER, which contains statistics for these target areas whether a hospice's data is of concern or not.
- The report shows a hospice's statistic in comparison to National, MAC, and jurisdiction and state statistics.
- Anything above the national average of 80% in the target areas are of concern and draws attention to these results. The greater the hospice percentile, the greater the risk for improper Medicare payment! Area of vulnerability for your agency!

61

How You Can Benefit From PEPPER?

- PEPPER is a tool that benefits various healthcare providers by offering detailed insights into Medicare billing patterns and identifying potential areas of improper payments.
- It allows users to access tables and graphs displaying billing activity over time, compare their data with other hospitals or facilities, and track changes in billing practices and Medicare reimbursement. It helps identify areas of potential overpayments and underpayments.
- PEPPER also assists in monitoring length of stay data, reviewing high-risk target areas for improper payment, and prioritizing areas for auditing and compliance monitoring.
- The report supports efforts to improve medical record documentation, monitor readmission rates, assess admission necessity, and enhance case management and discharge planning.
- Additionally, PEPPER helps identify potential DRG coding issues, improve coding compliance, and can be used for educational and training activities.
- Overall, PEPPER serves as a valuable resource for improving financial accuracy, compliance, and care quality within healthcare organizations

62

Target Pepper Areas and Live Discharges

1. Live Discharges

- **Live Discharges No Longer Terminally Ill:** Tracks the rate of beneficiaries discharged alive because they were no longer terminally ill.
- **Live Discharges – Revocations:** Measures the rate at which patients revoke their hospice benefit.
- **Live Discharges LOS 61 – 179 Days:** Monitors live discharges of patients with a length of stay between 61 and 179 days. (High rates here can sometimes trigger audits, as payment rates are higher for the first 60 days of Routine Home Care). PEPPER Resources +4

63

Suggested Interventions Hospices at Risk for Improper Payments (At/Above 80th Percentile)

Live Discharges – No Longer Terminally Ill

Live Discharges – Revocations

Live Discharges LOS 61-179 days

- For all three target areas related to live discharges:
  - This could indicate that beneficiaries are being enrolled in the Medicare hospice benefit who do not meet the hospice eligibility criteria.
  - The hospice should review Medicare hospice eligibility criteria and admissions procedures to ensure that beneficiaries are enrolled in the hospice benefit when they meet eligibility.
  - Criteria. Medical record documentation should be reviewed for beneficiaries discharged alive to determine if enrollment in the hospice benefit was appropriate and in accordance with Medicare policy. What is your agencies QA policy – review of live discharges?

64

Recommended Interventions for Hospice at Risk for Improper Payments **AT/ABOVE 80TH PERCENTILE

For Revocations:

- A high percentage of live discharges for beneficiary revocations could indicate improper beneficiary revocations are occurring.
- The hospice should review instances where occurrence code 42 is applied to ensure that the revocation was initiated by the beneficiary (not by the hospice) and that the revocation was not initiated to avoid costly patient care.

For LOS 61-179:

- Beginning October 1, 2015 (fiscal year 2016), hospice payments for RHC will decrease beginning on day 61.
- Beginning with FY2016, a high percentage of live discharges with a LOS 61-179 days could indicate that financial incentives are impacting patient care decisions.

65

Burdensome Transitions I and II

Live discharges from hospice with hospitalizations and readmissions within two days or with death occurring during hospitalization

Improving Outcomes/Scores

66

Burdensome Transitions Type I

Burdensome Transitions Type I

Live Hospice Discharge followed by **Hospitalization** and **Subsequent Readmission** within two days

Rationale

- Transitions between hospice and hospital often lead to fragmented care and associated with concerning care practices
  - Lack of Advance Care Planning to prevent hospitalizations
  - Agency not appropriately identifying hospice patients that are not stabilized prior to discharge
  - Ineffective discharge planning

67

Burdensome Transitions Type II

Burdensome Transitions Type II

Live Hospice Discharge followed by **Hospitalization** and **Patient Death** while in hospital

Rationale

- Hospitalization date has to occur no more than two days after hospice live discharge
- Pattern is associated with improper discharge processes that is not appropriately assessing stability of hospice patient's condition at time of discharge

68

Burdensome Transitions Chart Audits

What can you do to improve burdensome transitions?

- Audit all charts with patient re-election of hospice services within one week of discharge
  - Look for any trends (clinician, team, diagnosis)
  - Assess for any signs documented of decline prior to transfer
- Audit all revocations and/or ER transfers
  - Identify those that were revoked due to acute crisis (ER visit)
  - Identify any trends (clinician, team, diagnosis, facility)
- Track all live discharges by different time points identifying reasons for discharge (pattern/trend)
- Analysis on all discharges occurring within first seven days and after 180 days of care to identify any trends
  - Reason for discharge
  - Timing of discharge
  - Facility vs home patient
  - Clinicians
  - Days from referral to admission

69

Revocations Root Cause Analysis to Improve Burdensome Transitions

Root Cause Analysis for Revocations

- When was the hospice benefit elected, the timing?
- Seeking further treatment:
  - Documentation to support education hospice benefit
  - Discussion of desire to seek further treatment
  - Advanced Care Planning
- Symptom Management:
  - Was education provided on disease process, medications, hospice benefit?
  - Last visit any s/s of impending symptom issue identified and were interventions started?
    - Did patient/caregiver contact hospice first?
    - Did hospice respond timely?
    - Was visit provided?
    - Could symptom have been managed in the home?

70

Interventions to Improve Burdensome Transitions Revocations/ Early/Late Live Discharges

Assess how staff are explaining the hospice benefit

Patient/caregivers that are undecisive should be given option to have time to consider options.

- Don't admit if they are strongly undecisive
- Allow time for family to ask questions about hospice benefit
- Determine reasons for why they do not want to enroll in hospice
- Attempt to clear up misconceptions prior to admission
- Set plan to follow up in few days instead of admitting at that time (if appropriate)

Make sure all medications and DME are delivered timely

Ensure that patient/caregiver are aware of medications and PRN meds

71

Late Live Discharges – Burdensome Transition Interventions

High number of live discharges – no longer terminally ill:

- Educate staff on documenting IDT discussions regarding progression of disease process and eligibility status at each IDT.
- Clear documentation of patient decline and hospice eligibility throughout the episode documentation.
  - Documentation needs to address terminal diagnosis LCD.
- If patient is not declining – don't wait until 180 days to discharge.
  - If patient is no longer meeting eligibility or has not had any decline discussion/discharge should occur at that time not end of benefit period.
  - Discussion with patient/caregiver regarding hospice eligibility should occur on Admission and throughout benefit period.
  - If discharge is indicated – allow two weeks for discharge planning.

72

Late Live Discharges – Burdensome Transition Interventions

If high number of transfer to another hospice – analyze reason

- Did patient have prior service complaints?
- Did staff provide services outlined in plan of care?
- Related to a move to another facility – Is their opportunity to contract or provide services at that facility

If related to "discharge for cause"

- Review documentation to identify when the issue was first identified
- What attempts were made to rectify the issue
- Was this patient or employee issue
  - Safety issue for staff
  - Safety issue/noncompliance by patient

73

It All Comes Down to Oversight, Education and Analyzing the Trends

- Use your data to help guide you in identifying opportunity for improvement and decrease your percentages of live discharges and improve your quality scores.
- Performance Improvement Programs (PIPS) can help agency focus on outcome measures
- Agencies without clear processes for admissions tend to have higher transfers/revocations/medically ineligible/live discharges
- Agencies that do not educate, discuss, and use LCD guidelines may result in lower HCI scores for Burdensome Transfers, Live Discharges, and Higher Per Beneficiary Spending

74

How to Access PEPPER

Act Now: Get Ready to Access Your PEPPER

Authorized officials (AOs), access managers (AMs), and staff end users (SEUs) can access PEPPER through the PEPPER Portal.

How to get access as an SEU:

- Sign in to the CMS Identity & Access (I&A) System using your existing NPPES or PECOS credentials.
- Request the PEPPER business function for your organization. The Comparative Billing Report business function is also available and can be requested at the same time.
- Your AO or AM must approve your request.
- Once approved, log in to the portal and download your organization's report.

Take steps now to make sure you have access when we release your facility's PEPPER:

- See the I&A System Quick Reference Guide and FAQs: Step-by-step instructions for AOs and AMs
- Contact the External User Services Help Desk for assistance

https://www.cms.gov/training-education/medicare-learning-network/newsletter/mln-connects-newsletter-may-28-2026

75

References and Resources

References and Resources:

- https://www.cms.gov/files/document/hospice-monitoring-report-2026.pdf
- https://pepper.cbrpepper.org/index.html
- https://www.cms.gov/training-education/medicare-learning-network/newsletter/mln-connects-newsletter-may-28-2026
- https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-418

76

Thank You!

77